

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 6237 1-9-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 Race Street		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge d. STREET ADDRESS 406 Race Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Odie A. Andrew		4. DATE OF DEATH Month Day Year Dec. 30, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1881 9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Store Owner		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John A. Andrews	
14. MOTHER'S MAIDEN NAME Henrie tta Evans		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Leona Conway Address Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X HYPERTENSIVE-CARDIOVASCULAR DUE TO RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 13 MAR 1952 to 30 DEC 1958 that I last saw the deceased alive on 29 DEC 1958 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 CHURCH ST. CAMBRIDGE M.D. DATE SIGNED 31 DEC 58 ACTUAL SIGNATURE Walter E. Gunby Jr. PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR CAMBRIDGE M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 2, 1959	22c. NAME OF CEMETERY OR CREMATORY Cambridge Cem.	22d. LOCATION (City, town, or county) (State) Cambridge Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR DATE JAN 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13655

13678

Item 2 Film 257 12-29-58 60

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

6 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

E.S.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

Berlin

23X-2

d. STREET ADDRESS

Ocean City Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Nancy Mae Babcock

First

Middle

Last

4. DATE OF DEATH

12

20

19 58

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

Sept. 2 1877

9. AGE (In years last birthday)

81

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert Leonard

14. MOTHER'S MAIDEN NAME

Ellen Hankenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Address

Records E.S.S. Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Coronary ~~Obstruction~~ Occlusion

INTERVAL BETWEEN ONSET AND DEATH

Instant

420.1 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a. m.

p. m.

19

20d. INJURY OCCURRED

While

at work ☐

Not while

at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐. Inspection ☒. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

John Mace Jr.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

12/20/58

EXAMINER'S NAME (Type)

John Mace Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

12/24/1958

22c. NAME OF CEMETERY OR CREMATORY

NEWARK CEMETERY

22d. LOCATION (City, town, or county)

NEWARK (WAYNE Co.)

(State)

NEW YORK

23. FUNERAL DIRECTOR'S SIGNATURE

Thomas T. Waller, Salisbury, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

DATE DEC 23 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13665

CERTIFICATE OF DEATH

13656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linkwood Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Linkwood (Cambridge, Route # 2)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Id. Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy Banks</u> Middle _____ Last _____				4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-58</u>	
9. AGE (In years last birthday) yrs. _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Dor-Co-Md</u>	
12. CITIZEN OF WHAT COUNTRY? _____							
13. FATHER'S NAME <u>Leon Banks</u>				14. MOTHER'S MAIDEN NAME <u>Evangeline Wongus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Mrs. Evangeline Banks-Linkwood, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to difficult breech delivery</u> <u>760.0</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>tear of tentorium</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from <u>12-5-</u> <u>1958</u> , to <u>12-5-</u> <u>1958</u> , that I last saw the deceased alive on <u>12-5-</u> <u>1958</u> , and that death occurred at _____ M. , from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>12-13-58</u> PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem</u>		22d. LOCATION (City, town, or county) (State) <u>Salem, Dor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Huns</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 5/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison, Rural		c. LENGTH OF STAY IN 1b Secretary	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Highway between Woolford & Madison		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cecil Middle Rhodes Last Bradley		4. DATE OF DEATH Month Dec. Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/20/1902
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.	11. IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Henry Bradley		14. MOTHER'S MAIDEN NAME Anna Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Peggy Fuka		Address Sparrows Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial injuries 822x DUE TO Conditions, if any, which gave rise to immediate cause (b) Multiple fractures of skull (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was riding on front seat of car which overturned.	
20c. TIME OF INJURY Month, Day, Year 11:30 a.m. 12/13 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Madison, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED 12/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/58	
22c. NAME OF CEMETERY OR CREMATORY Vienna		22d. LOCATION (City, town, or county) (State) Vienna, Dor. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Willoughby, Edith S.		24a. REC'D BY REGISTRAR DEC 22 '58	
ADDRESS East New Market, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

CAUSE OF DEATH
MANNER OF DEATH
PLACE OF INTERMENT

DATE OF EXAMINATION
TIME OF EXAMINATION
PLACE OF EXAMINATION

NAME OF EXAMINER
ADDRESS OF EXAMINER
CITY OF EXAMINER

DATE OF REPORT
TIME OF REPORT
PLACE OF REPORT

NAME OF REPORTER
ADDRESS OF REPORTER
CITY OF REPORTER

DATE OF REPORT
TIME OF REPORT
PLACE OF REPORT

13679

CERTIFICATE OF DEATH

14428

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elwood				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural			
d. STREET ADDRESS Elwood				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Blanche Middle Clark Last Bowdle				4. DATE OF DEATH Month December Day 31 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 1, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter A. Coulbourn				14. MOTHER'S MAIDEN NAME Emma C. Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-16-3585		17. INFORMANT Mrs. Grace Gordy, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Respiratory infection							INTERVAL BETWEEN ONSET AND DEATH 0 ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1958 Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 10-25, 1958 , to 12-31, 1958 , that I last saw the deceased alive on 12-1, 1958 , and that death occurred at 1 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. R. Trapnell				ADDRESS (Street, city or town, state) 126 Blomington Ave Federalburg, Md			
DATE SIGNED 1-5-59							
PHYSICIAN'S NAME (Type) H. R. Trapnell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE JAN 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14438

CERTIFICATE OF DEATH

18678

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED</p> <p>AGE</p> <p>SEX</p> <p>RACE</p> <p>DATE OF BIRTH</p> <p>PLACE OF BIRTH</p> <p>DATE OF DEATH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>PERIOD OF ILLNESS</p> <p>PREVIOUS ILLNESS</p> <p>PREVIOUS SURGERY</p> <p>PREVIOUS TRAUMA</p> <p>PREVIOUS DRUGS</p> <p>PREVIOUS ALCOHOL</p> <p>PREVIOUS TOBACCO</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS MEDICAL HISTORY</p> <p>PREVIOUS SURVIVAL</p> <p>PREVIOUS DEATH</p> <p>PREVIOUS CAUSE</p> <p>PREVIOUS PLACE</p> <p>PREVIOUS DATE</p> <p>PREVIOUS TIME</p> <p>PREVIOUS LOCATION</p> <p>PREVIOUS WEATHER</p> <p>PREVIOUS MOON</p> <p>PREVIOUS STARS</p> <p>PREVIOUS PLANETS</p> <p>PREVIOUS SIGNS</p> <p>PREVIOUS HOUSES</p> <p>PREVIOUS ASPECTS</p> <p>PREVIOUS ECLIPSES</p> <p>PREVIOUS CONJUNCTIONS</p> <p>PREVIOUS SEPARATIONS</p> <p>PREVIOUS SQUARES</p> <p>PREVIOUS TRINES</p> <p>PREVIOUS SEXTILES</p> <p>PREVIOUS OCTILES</p> <p>PREVIOUS NOXONS</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS MEDICAL HISTORY</p> <p>PREVIOUS SURVIVAL</p> <p>PREVIOUS DEATH</p> <p>PREVIOUS CAUSE</p> <p>PREVIOUS PLACE</p> <p>PREVIOUS DATE</p> <p>PREVIOUS TIME</p> <p>PREVIOUS LOCATION</p> <p>PREVIOUS WEATHER</p> <p>PREVIOUS MOON</p> <p>PREVIOUS STARS</p> <p>PREVIOUS PLANETS</p> <p>PREVIOUS SIGNS</p> <p>PREVIOUS HOUSES</p> <p>PREVIOUS ASPECTS</p> <p>PREVIOUS ECLIPSES</p> <p>PREVIOUS CONJUNCTIONS</p> <p>PREVIOUS SEPARATIONS</p> <p>PREVIOUS SQUARES</p> <p>PREVIOUS TRINES</p> <p>PREVIOUS SEXTILES</p> <p>PREVIOUS OCTILES</p> <p>PREVIOUS NOXONS</p> <p>PREVIOUS OTHER</p>	
---	--

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market - Rural		c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market - Rural		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Mission			d. STREET ADDRESS Near Mission		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Durenda Middle Lorett Last Camper			4. DATE OF DEATH Month December Day 3 Year 19 58		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1958		9. AGE (In years last birthday) yrs. 1 Months 18 Days 2 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
13. FATHER'S NAME Charles Monroe Camper			14. MOTHER'S MAIDEN NAME Viola Mae Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Charles Monroe Johnson, East New Market, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Dec. 4, 1958	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 4, 1958	22c. NAME OF CEMETERY OR CREMATORY Thompsons town Cemetery		22d. LOCATION (City, town, or county) (State) Near East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE DEC 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

40 00318XV6

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

INTERNAL ORGANS

EXTERNAL ORGANS

PATHOLOGICAL FINDINGS

LABORATORY TESTS

RADIOLOGICAL TESTS

TOXICOLOGICAL TESTS

ANTHROPOLOGICAL TESTS

FOOTPRINTS

PHOTOGRAPHS

IDENTIFICATION

SIGNATURE

DATE

PLACE

TIME

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

13682 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural				c. LENGTH OF STAY IN 1b 13 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Reid's Grove				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Joseph Last Carneal				4. DATE OF DEATH Month December Day 2 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1892		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber hauling and Farming				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Caroline Co., Virginia	
13. FATHER'S NAME Wilbur Carneal				14. MOTHER'S MAIDEN NAME Eleanor Carneal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-9048		17. INFORMANT Mrs. Lannie E. Carneal, Vienna, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anginal attack 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Distention (c) Heart Condition						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 58 to Nov 25 19 58 that I last saw the deceased alive on Nov 25 19 58 , and that death occurred at 1:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Federalburg, Maryland DATE SIGNED Fred C. Quinn							
ACTUAL SIGNATURE Fred C. Quinn M.D.				DATE SIGNED DEC 8 '58			
PHYSICIAN'S NAME (Type) FRED. C. QUINN				DATE SIGNED DEC 8 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalburg, Maryland	
23. J. J. FRAMPTON AND SON, FEDERALBURG, MARYLAND				24a. REC'D BY REGISTRAR DEC 8 '58		24b. REGISTRAR'S SIGNATURE C. L. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
SEX MALE		AGE 25	
OCCUPATION LABORER		CAUSE OF DEATH DISEASE OF THE HEART	
DATE OF DEATH JAN 15 1902		TIME OF DEATH 10:30 AM	
PLACE OF INTERMENT CATHOLIC CHURCH		NAME OF PHYSICIAN DR. J. H. SMITH	
NAME OF DECEASED JOHN J. SMITH		NAME OF NEXT OF KIN MARY J. SMITH	
ADDRESS OF DECEASED 123 N. BALTIMORE ST.		ADDRESS OF NEXT OF KIN 456 E. BALTIMORE ST.	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF NEXT OF KIN MARY J. SMITH	
SIGNATURE OF REGISTRAR W. J. BROWN		SIGNATURE OF CLERK A. C. GREEN	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13683

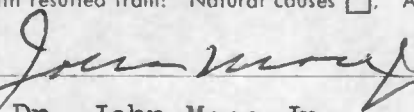

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13660

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market		c. LENGTH OF STAY IN life Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daisy		First Cephas		4. DATE OF DEATH Month Dec. Day 11 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1909	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel J. Young		14. MOTHER'S MAIDEN NAME Mary Ida Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Lewis Cephas Address Hurlock, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Burns entire body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in fire which destroyed home.			
20c. TIME OF INJURY Month, Day, Year 12/11/58 Hour 10:30 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) East New Market, Dor. Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/58		22c. NAME OF CEMETERY OR CREMATORY East New Market	
22d. LOCATION (City, town, or county) East New Market, Dor. Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St Clair		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DEC 19 58	
				24b. REGISTRAR'S SIGNATURE 	

FOR STATE
HEALTH DEPT.

1913

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12000

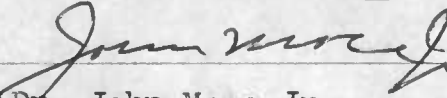

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		45		Male		White		Methodist	
PLACE OF BIRTH		DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
Baltimore, Md.		Jan 15, 1868		Jan 15, 1913		10:30 A.M.		Home	
CAUSE OF DEATH		DISEASE		MORBID ANATOMY		GROSS ANATOMY		MICROSCOPIC	
Heart failure		Coronary atherosclerosis		Myocardial degeneration		Coronary atherosclerosis		Myocardial degeneration	
MORBID ANATOMY		GROSS ANATOMY		MICROSCOPIC		TOXICOLOGICAL		OTHER	
Heart failure		Coronary atherosclerosis		Myocardial degeneration		Coronary atherosclerosis		Myocardial degeneration	
TOXICOLOGICAL		OTHER		SIGNATURE OF EXAMINER		DATE		PLACE	
				J. H. Harris		Jan 15, 1913		Baltimore, Md.	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13684 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Le Roy Middle Ward Last Cephas			4. DATE OF DEATH Month Dec. Day 11 Year 19 58		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 30, 1898		9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Robert Cephas			14. MOTHER'S MAIDEN NAME Martina Cephas		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Lewis Cephas Address Hurlock, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns entire body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in fire which destroyed his home.			
20c. TIME OF INJURY Month, Day, Year 10:30 a.m. 12/11 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) East New Market, Dor. Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/58		22c. NAME OF CEMETERY OR CREMATORY East New Market Cem.	
22d. LOCATION (City, town, or county) East New Market, Dor. Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE StClair Funeral			24a. REC'D BY REGISTRAR DATE DEC 19 '58		
24b. REGISTRAR'S SIGNATURE 					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-24

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1883

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		Roman Catholic		Married		High School		Teacher		123 Main St, Baltimore, Md.		October 24, 1924		Home	
CAUSE OF DEATH																					
Died in line with previous illness.																					
1. Cause of Death																					
2. Contributing Cause																					
3. Immediate Cause																					
4. Underlying Cause																					
5. Manner of Death																					
6. Signature of Medical Examiner																					
7. Signature of Coroner																					
8. Signature of Registrar																					
9. Signature of Witness																					
10. Signature of Physician																					
11. Signature of Nurse																					
12. Signature of Undertaker																					
13. Signature of Burial Society																					
14. Signature of Cemetery																					
15. Signature of Funeral Home																					
16. Signature of Mortician																					
17. Signature of Embalmer																					
18. Signature of Preparator																					
19. Signature of Restroom Attendant																					
20. Signature of Burial Vault Attendant																					
21. Signature of Grave Digger																					
22. Signature of Grave Marker																					
23. Signature of Grave Keeper																					
24. Signature of Graveyard Superintendent																					
25. Signature of Graveyard Association																					
26. Signature of Graveyard Board																					
27. Signature of Graveyard Committee																					
28. Signature of Graveyard Trustees																					
29. Signature of Graveyard Owners																					
30. Signature of Graveyard Lessees																					
31. Signature of Graveyard Leases																					
32. Signature of Graveyard Deeds																					
33. Signature of Graveyard Easements																					
34. Signature of Graveyard Encroachments																					
35. Signature of Graveyard Eminent Domain																					
36. Signature of Graveyard Condemnation																					
37. Signature of Graveyard Relocation																					
38. Signature of Graveyard Relocation Order																					
39. Signature of Graveyard Relocation Hearing																					
40. Signature of Graveyard Relocation Decision																					
41. Signature of Graveyard Relocation Appeal																					
42. Signature of Graveyard Relocation Appeal Decision																					
43. Signature of Graveyard Relocation Final Order																					
44. Signature of Graveyard Relocation Final Decision																					
45. Signature of Graveyard Relocation Final Appeal																					
46. Signature of Graveyard Relocation Final Appeal Decision																					
47. Signature of Graveyard Relocation Final Appeal Final Order																					
48. Signature of Graveyard Relocation Final Appeal Final Decision																					
49. Signature of Graveyard Relocation Final Appeal Final Appeal																					
50. Signature of Graveyard Relocation Final Appeal Final Appeal Decision																					

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13685

13662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market	c. LENGTH OF STAY IN Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LeRoy Webster Cephas		4. DATE OF DEATH Month Dec. Day 11, Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1937
9. AGE (In years, last birthday) 21 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME LeRoy Ward Cephas		14. MOTHER'S MAIDEN NAME Daisy Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Lewis Cephas Address Hurlock, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in Home which was destroyed by fire.	
20c. TIME OF INJURY Month, Day, Year Hour 10:30 a.m. 12/11/58	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) East New Market, Dor. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/15/58	22c. NAME OF CEMETERY OR CREMATORY East new Market	22d. LOCATION (City, town, or county) (State) East New Market, Dor. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St Clair ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE DEC 19 '58	24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION			
John Doe		45		Male		White		Roman Catholic		Married		High School		Farmer		123 Main St.		Jan 15, 1918		At Home		Heart Disease		Natural		J. A. Smith		Jan 16, 1918		Baltimore, Md.			
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		BIRTH TIME		BIRTH WEIGHT		BIRTH LENGTH		BIRTH CIRCUMFERENCE		BIRTH SEX		BIRTH RACE		BIRTH RELIGION		BIRTH MARRIAGE		BIRTH EDUCATION		BIRTH OCCUPATION		BIRTH RESIDENCE		BIRTH DATE OF DEATH		BIRTH PLACE OF DEATH	
John Doe		Jane Doe		Jan 1, 1873		Maryland		10:00 AM		15 lbs		20 in		13 in		Male		White		Roman Catholic		Married		High School		Farmer		123 Main St.		Jan 1, 1918		At Home	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		BIRTH TIME		BIRTH WEIGHT		BIRTH LENGTH		BIRTH CIRCUMFERENCE		BIRTH SEX		BIRTH RACE		BIRTH RELIGION		BIRTH MARRIAGE		BIRTH EDUCATION		BIRTH OCCUPATION		BIRTH RESIDENCE		BIRTH DATE OF DEATH		BIRTH PLACE OF DEATH	
John Doe		Jane Doe		Jan 1, 1873		Maryland		10:00 AM		15 lbs		20 in		13 in		Male		White		Roman Catholic		Married		High School		Farmer		123 Main St.		Jan 1, 1918		At Home	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13686

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nathaniel Middle Cephas Last 		4. DATE OF DEATH Month Dec. Day 11, Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/20
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME LeRoy Ward Cephas	
14. MOTHER'S MAIDEN NAME Daisy Young		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 	
16. SOCIAL SECURITY NO. 		17. INFORMANT Lewis Cephas Hurlock, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns entire body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in fire which destroyed home.	
20c. TIME OF INJURY Month, Day, Year 10:30 P.M. 12/11/58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) East New Market, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED 12/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/58	
22c. NAME OF CEMETERY OR CREMATORY East New Market		22d. LOCATION (City, town, or county) (State) East New Market, Dor. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DEC 19 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kneal	

I

09

2

op

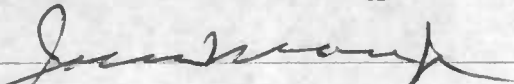
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13664

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market		c. LENGTH OF STAY IN lb Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ralph Middle H. Last Cephas			4. DATE OF DEATH Month Dec. Day 11, Year 19 58		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 1, 1945		9. AGE (In years last birthday) 13 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attend school		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.			13. FATHER'S NAME LeRoy Ward Cephas		
14. MOTHER'S MAIDEN NAME Daisy Young			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lewis Cephas Hurlock, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in home which was destroyed by fire.			
20c. TIME OF INJURY Month, Day, Year 10:30 P.M. 12/11/58		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) East New Market, Dor. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/58		22c. NAME OF CEMETERY OR CREMATORY East New Market	
22d. LOCATION (City, town, or county) (State) East New Market, Dor. Md.		22e. FUNERAL DIRECTOR'S SIGNATURE Herbert St Clair		22f. ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			

DEC 19 58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13666 CERTIFICATE OF DEATH

13665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle A. Last Crippen				4. DATE OF DEATH Month Dec 2 Day 19 Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1875	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Crippen				14. MOTHER'S MAIDEN NAME Sarah Snowden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1898 - 1918 135 20 1456		17. INFORMANT Mrs Anna Crippen Cambridge Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 6 YEARS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS 10 YEARS DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 13 FEB 58 , to 2 DEC 58 , that I last saw the deceased alive on 1 DEC 58 , and that death occurred at 4 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter E. Gunby Jr				ADDRESS (Street, city or town, state) 105 CHURCH ST			
DATE SIGNED 3 DEC 58				DATE SIGNED			
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR				CAMBRIDGE M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 4 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Maryland		24a. REC'D BY REGISTRAR DEC 4 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank							

1966 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED (Print or type full name)		SEX (Male or Female)		RACE (Print or type)	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)		DATE OF DEATH (Month, day, year)	
TIME OF DEATH (Hour, minute)		PLACE OF DEATH (City, State, Country)		CAUSE OF DEATH (Print or type)	
MANNER OF DEATH (Natural, Accidental, Homicide, Suicide, Unknown)		MEDICAL HISTORY (Print or type)		PRESENT ILLNESS (Print or type)	
SIGNATURE OF DECEASED (Print or type)		SIGNATURE OF WITNESS (Print or type)		SIGNATURE OF PHYSICIAN (Print or type)	
SIGNATURE OF MARRIAGE OFFICIAL (Print or type)		SIGNATURE OF CLERK (Print or type)		SIGNATURE OF REGISTRAR (Print or type)	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It is to be filed with the local health department or the State Department of Health. The information on this certificate is used for statistical purposes only. It is not to be used for legal purposes.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13666

13667

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 12 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Race Street				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hazel First Phillips Middle Dail Last				4. DATE OF DEATH Dec. Month 30 Day 19 Year 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 11, 1891	
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George T. Phillips				14. MOTHER'S MAIDEN NAME Susie Keene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO		17. INFORMANT Herbert H. Dail Address Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA CERVIX - UTERI 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-23-51 , 19____, to 12-30-58 , 19____, that I last saw the deceased alive on 12-29-58 , 19____, and that death occurred at 4:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 12-31-58 ACTUAL SIGNATURE Albert E. Bunker M.D. 200 Maryland Avenue PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D. Cambridge, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JAN 2, 1959		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cem.		22d. LOCATION (City, town, or county) (State) Cambridge Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Maryland		24a. REC'D BY REGISTRAR JAN 5 '59	
				24b. REGISTRAR'S SIGNATURE Carlton L. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

19

► **Future research**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13667

13688 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN 1b 55 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eldorado Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Calvin Last Davis		4. DATE OF DEATH Month December Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer and Timber Operator		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co., Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Levin Davis		14. MOTHER'S MAIDEN NAME Mary Givens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Carrie M. Davis, Federalsburg, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis - DUE TO with Senility (c) with Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I INTERVAL BETWEEN ONSET AND DEATH 3 days several years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 13, 1958 to Dec 13, 1958 , that I last saw the deceased alive on Dec 13, 1958 , and that death occurred at 8:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Lennon M.D.		ADDRESS (Street, city or town, state) Federalsburg Md. DATE SIGNED Dec. 15, 1958	
PHYSICIAN'S NAME (Type) W. E. Lennon, M.D.		Federalsburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 16, 1958	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery	22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS DEC 22 '58	
24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

10028 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

1. NAME OF DECEASED (Print name in full)		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE (In years, months, and days)		4. RACE (Print race)	
5. DATE OF BIRTH (Month, day, and year)		6. PLACE OF BIRTH (City, State, and Country)	
7. DATE OF DEATH (Month, day, and year)		8. PLACE OF DEATH (City, State, and Country)	
9. TIME OF DEATH (Hour and minute)		10. CAUSE OF DEATH (Print cause of death)	
11. MANNER OF DEATH (Print manner of death)		12. SIGNATURE OF DECEASED (If known)	
13. SIGNATURE OF WITNESS (Print name and address)		14. SIGNATURE OF DECEASED (If known)	
15. SIGNATURE OF WITNESS (Print name and address)		16. SIGNATURE OF DECEASED (If known)	
17. SIGNATURE OF WITNESS (Print name and address)		18. SIGNATURE OF DECEASED (If known)	
19. SIGNATURE OF WITNESS (Print name and address)		20. SIGNATURE OF DECEASED (If known)	
21. SIGNATURE OF WITNESS (Print name and address)		22. SIGNATURE OF DECEASED (If known)	
23. SIGNATURE OF WITNESS (Print name and address)		24. SIGNATURE OF DECEASED (If known)	
25. SIGNATURE OF WITNESS (Print name and address)		26. SIGNATURE OF DECEASED (If known)	
27. SIGNATURE OF WITNESS (Print name and address)		28. SIGNATURE OF DECEASED (If known)	
29. SIGNATURE OF WITNESS (Print name and address)		30. SIGNATURE OF DECEASED (If known)	
31. SIGNATURE OF WITNESS (Print name and address)		32. SIGNATURE OF DECEASED (If known)	
33. SIGNATURE OF WITNESS (Print name and address)		34. SIGNATURE OF DECEASED (If known)	
35. SIGNATURE OF WITNESS (Print name and address)		36. SIGNATURE OF DECEASED (If known)	
37. SIGNATURE OF WITNESS (Print name and address)		38. SIGNATURE OF DECEASED (If known)	
39. SIGNATURE OF WITNESS (Print name and address)		40. SIGNATURE OF DECEASED (If known)	
41. SIGNATURE OF WITNESS (Print name and address)		42. SIGNATURE OF DECEASED (If known)	
43. SIGNATURE OF WITNESS (Print name and address)		44. SIGNATURE OF DECEASED (If known)	
45. SIGNATURE OF WITNESS (Print name and address)		46. SIGNATURE OF DECEASED (If known)	
47. SIGNATURE OF WITNESS (Print name and address)		48. SIGNATURE OF DECEASED (If known)	
49. SIGNATURE OF WITNESS (Print name and address)		50. SIGNATURE OF DECEASED (If known)	
51. SIGNATURE OF WITNESS (Print name and address)		52. SIGNATURE OF DECEASED (If known)	
53. SIGNATURE OF WITNESS (Print name and address)		54. SIGNATURE OF DECEASED (If known)	
55. SIGNATURE OF WITNESS (Print name and address)		56. SIGNATURE OF DECEASED (If known)	
57. SIGNATURE OF WITNESS (Print name and address)		58. SIGNATURE OF DECEASED (If known)	
59. SIGNATURE OF WITNESS (Print name and address)		60. SIGNATURE OF DECEASED (If known)	
61. SIGNATURE OF WITNESS (Print name and address)		62. SIGNATURE OF DECEASED (If known)	
63. SIGNATURE OF WITNESS (Print name and address)		64. SIGNATURE OF DECEASED (If known)	
65. SIGNATURE OF WITNESS (Print name and address)		66. SIGNATURE OF DECEASED (If known)	
67. SIGNATURE OF WITNESS (Print name and address)		68. SIGNATURE OF DECEASED (If known)	
69. SIGNATURE OF WITNESS (Print name and address)		70. SIGNATURE OF DECEASED (If known)	
71. SIGNATURE OF WITNESS (Print name and address)		72. SIGNATURE OF DECEASED (If known)	
73. SIGNATURE OF WITNESS (Print name and address)		74. SIGNATURE OF DECEASED (If known)	
75. SIGNATURE OF WITNESS (Print name and address)		76. SIGNATURE OF DECEASED (If known)	
77. SIGNATURE OF WITNESS (Print name and address)		78. SIGNATURE OF DECEASED (If known)	
79. SIGNATURE OF WITNESS (Print name and address)		80. SIGNATURE OF DECEASED (If known)	
81. SIGNATURE OF WITNESS (Print name and address)		82. SIGNATURE OF DECEASED (If known)	
83. SIGNATURE OF WITNESS (Print name and address)		84. SIGNATURE OF DECEASED (If known)	
85. SIGNATURE OF WITNESS (Print name and address)		86. SIGNATURE OF DECEASED (If known)	
87. SIGNATURE OF WITNESS (Print name and address)		88. SIGNATURE OF DECEASED (If known)	
89. SIGNATURE OF WITNESS (Print name and address)		90. SIGNATURE OF DECEASED (If known)	
91. SIGNATURE OF WITNESS (Print name and address)		92. SIGNATURE OF DECEASED (If known)	
93. SIGNATURE OF WITNESS (Print name and address)		94. SIGNATURE OF DECEASED (If known)	
95. SIGNATURE OF WITNESS (Print name and address)		96. SIGNATURE OF DECEASED (If known)	
97. SIGNATURE OF WITNESS (Print name and address)		98. SIGNATURE OF DECEASED (If known)	
99. SIGNATURE OF WITNESS (Print name and address)		100. SIGNATURE OF DECEASED (If known)	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13689 CERTIFICATE OF DEATH

13668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		c. LENGTH OF STAY IN 1b 4 yrs. 3 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Rumbold Last Dunham		4. DATE OF DEATH Month December Day 19 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1865
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR: Months 93 Days 93 Hours 93 Min. 93	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Rumbold		14. MOTHER'S MAIDEN NAME Mary Frances Andrew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT E.S.S. Hospital records, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH Unknown 11			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-18- 1954 , to 12-19- 1958 , that I last saw the deceased alive on 12-19- 1958 , and that death occurred at 7:03 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rt. 2, Cambridge, Md. DATE SIGNED 12-19-58 ACTUAL SIGNATURE George E. Currier M.D. PHYSICIAN'S NAME (Type) George E. Currier, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 21, 1958	
22c. NAME OF CEMETERY OR CREMATORY Linchester Cemetery		22d. LOCATION (City, town, or county) (State) Near Preston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Hampton, Son		ADDRESS Frederick, Md.	
24a. REC'D BY REGISTRAR DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13083 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

13083

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
MARRIAGE [Faint text, possibly "Married"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "10/25/1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]		SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]	
DATE OF SIGNATURE [Faint text, possibly "10/25/1955"]		DATE OF SIGNATURE [Faint text, possibly "10/25/1955"]		DATE OF SIGNATURE [Faint text, possibly "10/25/1955"]		DATE OF SIGNATURE [Faint text, possibly "10/25/1955"]		DATE OF SIGNATURE [Faint text, possibly "10/25/1955"]	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>7 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u> 14X-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First <u>SCOTT</u> Middle <u>GODWIN</u> Last			4. DATE OF DEATH <u>DECEMBER</u> Month <u>27</u> Day <u>1958</u> Year		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-1-72</u>	9. AGE (in years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>BENJAMIN SCOTT GODWIN</u>		
14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>218-32-5364</u>			17. INFORMANT <u>EASTERN SHORE STATE HOSP. RECORDS</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>904.7</u> DUE TO <u>TERMINAL PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (b) <u>2 days</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> DUE TO <u>2 days</u> cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Injury with laceration</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11-27-1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) <u>Cambridge</u>	(County) <u>MD</u>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/28/58</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 30, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Crompton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crompton</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Feltz</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		
24a. REC'D BY REGISTRAR DATE <u>DEC 31 '58</u>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE

TIME

PLACE

Cause

Manner

Signature

Witness

Coroner

Physician

Funeral

Interment

Remarks

Signature

Witness

Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13671

13663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lula Middle Richardson Last Goslee		4. DATE OF DEATH Month December Day 19 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Church Creek, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Skinner Richardson		14. MOTHER'S MAIDEN NAME Mary E. Asplen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Julian Richardson, East New Market, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 Cerebral Hemorrhage DUE TO Coronary Arteriosclerosis CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3 yrs DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 4-6-1956 to 12-19-1958 , that I last saw the deceased alive on 12-19-1958 , and that death occurred at 8:10 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE W. Bannmann M.D. ADDRESS (Street, city or town, state) Cambridge, Md DATE SIGNED 5-10-20 PHYSICIAN'S NAME (Type) Arthur S. Howard 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Dec. 22, 1958 22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery 22d. LOCATION (City, town, or county) (State) East New Market, Md. 23. FUNERAL DIRECTOR'S SIGNATURE Ernest R. Howard ADDRESS Cambridge, Md. 24a. REC'D BY REGISTRAR DATE DEC 23 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13669

CERTIFICATE OF DEATH

Reg. Dist. No.

13672

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) Cambridge Maryland Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Phillip M. Hasting				4. DATE OF DEATH Month Dec Day 25 Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1958		9. AGE (In years last birthday) yrs. 5	IF UNDER 1 YEAR Months 12 Days 12	IF UNDER 24 HRS. Hours 12 Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N one		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harold R. Hasting				14. MOTHER'S MAIDEN NAME Thelma M Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Harold Hasting Address Cambridge Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE GASTROENTERITIS 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA 493x INTERVAL BETWEEN ONSET AND DEATH 5 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 7-13-58 , 19 58 , to 12-25-58 , 19 58 , that I last saw the deceased alive on 12-25-58 , and that death occurred at 7:19 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Ave., Cambridge, Maryland DATE SIGNED 12-26-58							
ACTUAL SIGNATURE <i>Albert E. Bunker</i>		M.D. 200 Maryland Ave., Cambridge, Maryland					
PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.		Cambridge, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 26, 1958	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Park		22d. LOCATION (City, town, or county) (State) Cambridge Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Maryland.		24a. REC'D BY REGISTRAR DEC 29 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hanks</i>

2067213XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13673

13670

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Md Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u></u> Last <u>Horsey</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester-Co-Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Major Horsey</u>				14. MOTHER'S MAIDEN NAME <u>Mandy Stanley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-18-4184</u>		17. INFORMANT <u>Sarah Henson, Cambridge, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>February 13, 19 53</u> , to <u>December 6, 19 58</u> , that I last saw the deceased alive on <u>December 6, 19 58</u> , and that death occurred at <u></u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>12-13-58</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. <u>J. Edwin Fassett, M.D.</u> PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bucktown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. S. H. H. H.</u> ADDRESS <u>Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H. H.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____		MARITAL STATUS _____		COLOR _____	
STREET ADDRESS _____		CITY _____		COUNTY _____		STATE _____	
DECEASED AT HOME <input type="checkbox"/>		DECEASED IN HOSPITAL <input type="checkbox"/>		DECEASED IN ASYLUM <input type="checkbox"/>		DECEASED IN OTHER PLACE <input type="checkbox"/>	
CAUSE OF DEATH _____		MANNER OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____		SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
DATE _____		TIME _____		PLACE _____		COUNTY _____	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13674

13692 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenridge St., Federalsburgh, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Greenridge Street. 05X-2	
3. NAME OF DECEASED (Type or print) First Carrie Middle Chaffinch Last Hubbard		4. DATE OF DEATH Month Dec. Day 19 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1864
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Chaffinch		14. MOTHER'S MAIDEN NAME Alexine Rich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None--	
17. INFORMANT Records-Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3- , 19 58 , to 12-19-58 , 19 58 , that I last saw the deceased alive on 12-18- , 19 58 , and that death occurred at 8:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Maryland DATE SIGNED 12-19-58 ACTUAL SIGNATURE Ettore DeFilippis M.D. PHYSICIAN'S NAME (Type) Ettore DeFilippis, M.D. Eastern Shore State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 21, 1958	
22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery		22d. LOCATION (City, town, or county) (State) Near Federalsburgh, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburgh, Maryland		24a. REC'D BY REGISTRAR DEC 29 58 DATE	
24b. REGISTRAR'S SIGNATURE Wm. S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10									
CERTIFICATE OF DEATH									
NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		EDUCATION	
JAMES H. HARRIS		JAN 15 1900		M		W		HIGH SCHOOL	
RESIDENCE		CITY		COUNTY		STATE		ZIP	
1234 E. MAIN ST.		BALTIMORE		BALTIMORE		MD		21201	
OCCUPATION		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
LABORER		JAN 18 1960		10:30 AM		HOME		HEART DISEASE	
PREVIOUS ILLNESS		DATE OF LAST ILLNESS		DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN		HOSPITAL	
NONE		JAN 15 1960		JAN 15 1960		DR. J. H. HARRIS		NONE	
MANNER OF DEATH		DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		CITY	
NATURAL		JAN 18 1960		10:30 AM		CATHOLIC CHURCH		BALTIMORE	
DATE OF INTERVIEW		NAME OF INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
JAN 18 1960		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF FILING		NAME OF FILER		SIGNATURE OF FILER		SIGNATURE OF CLERK		SIGNATURE OF PHYSICIAN	
JAN 18 1960		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

1

13693 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reid's Grove				/ d. STREET ADDRESS Reid's Grove			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Washington Last Hughes				4. DATE OF DEATH Month December Day 2 Year 19 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1889		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Emma M. Hughes, Rhodesdale, Maryland, RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month Day 19 Year p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1956 , to Dec 2, 1958 , that I last saw the deceased alive on Nov 30, 1958 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. S. Kuhlman		M.D. Sharpton - Md		ADDRESS (Street, city or town, state) 		DATE SIGNED 12/2/58	
PHYSICIAN'S NAME (Type) H. S. Kuhlman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Reid's Grove Cemetery		22d. LOCATION (City, town, or county) (State) Rhodesdale, Md., R.F.D.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13694 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>9 mos. 13 das.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Massey</u>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Eola</u> Last <u>Malsberger</u>				4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 1, 1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Eastern Shore State Hospital records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>March 17, 1958</u> , to <u>December 30, 1958</u> , that I last saw the deceased alive on <u>December 30, 1958</u> , and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Simon Virkutis</u> M.D.				PHYSICIAN'S NAME (Type) <u>Simon Virkutis, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Jan 2, 1959</u>				22b. DATE THEREOF <u>Jan 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Massey Cem.</u>	
22d. LOCATION (City, town, or county) <u>Massey Md.</u>				22e. (State) <u>Md.</u>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund S. Galloway</u>				ADDRESS <u>Washington</u>		24a. REC'D BY REGISTRAR <u>Jan 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles L. Frank</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD # 3 Cambridge		c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. 3V01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Farm, Ross Neck, Dor Co., Md.			d. STREET ADDRESS 112 Witherspoon Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Oliver Jackson Marston			4. DATE OF DEATH Month 12 Day 26 Year 19 58		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1910		9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice Pres.		10b. KIND OF BUSINESS OR INDUSTRY Wholesale floor coverings		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Cooper T. Marston			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			14. MOTHER'S MAIDEN NAME Eugenia Haines		
16. SOCIAL SECURITY NO.			17. INFORMANT Marston Elanor Mac Donald, Baltimore, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) JOHN MACE JR.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/58		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetary	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.			24a. REC'D BY REGISTRAR DATE DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

6

00

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13696 CERTIFICATE OF DEATH

Reg. Dist. No. 13678

1. PLACE OF DEATH o. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>P.O. Office Seaford, Del.</u>			
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Jane</u> Last <u>McCarter</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>20th</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 17, 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Elsie M. Hitchens, Delmar, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Hemiplegia</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>8 days</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-10</u> , 19 <u>52</u> , to <u>12-20</u> , 19 <u>58</u> that I last saw the deceased alive on <u>12-19</u> , 19 <u>58</u> , and that death occurred at <u>7:20</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Larry Blum</u> M.D.				ADDRESS (Street, city or town, state) <u>Preston Md</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr. H. B. Plummer</u>				<u>Preston Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Hurlock, Md. RFD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Marvel, Shaysboro, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

INDIAN STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

<p>1. NAME OF DECEASED JAMES ROBERTSON</p>		<p>2. SEX Male</p>		<p>3. AGE 35</p>	
<p>4. DATE OF DEATH Dec. 10, 1900</p>		<p>5. TIME OF DEATH 10:00 AM</p>		<p>6. PLACE OF DEATH Home</p>	
<p>7. CAUSE OF DEATH Pneumonia</p>		<p>8. MANNER OF DEATH Natural</p>		<p>9. PLACE OF BIRTH Maryland</p>	
<p>10. OCCUPATION Farmer</p>		<p>11. EDUCATION None</p>		<p>12. RELIGION None</p>	
<p>13. MARITAL STATUS Married</p>		<p>14. DATE OF MARRIAGE Jan. 15, 1895</p>		<p>15. NAME OF SPOUSE Mary Jane</p>	
<p>16. NAME OF FATHER John</p>		<p>17. NAME OF MOTHER Sarah</p>		<p>18. NAME OF BIRTHPLACE Maryland</p>	
<p>19. NAME OF PRESENT RESIDENCE None</p>		<p>20. NAME OF PREVIOUS RESIDENCE None</p>		<p>21. NAME OF PREVIOUS RESIDENCE None</p>	
<p>22. NAME OF PREVIOUS RESIDENCE None</p>		<p>23. NAME OF PREVIOUS RESIDENCE None</p>		<p>24. NAME OF PREVIOUS RESIDENCE None</p>	
<p>25. NAME OF PREVIOUS RESIDENCE None</p>		<p>26. NAME OF PREVIOUS RESIDENCE None</p>		<p>27. NAME OF PREVIOUS RESIDENCE None</p>	
<p>28. NAME OF PREVIOUS RESIDENCE None</p>		<p>29. NAME OF PREVIOUS RESIDENCE None</p>		<p>30. NAME OF PREVIOUS RESIDENCE None</p>	
<p>31. NAME OF PREVIOUS RESIDENCE None</p>		<p>32. NAME OF PREVIOUS RESIDENCE None</p>		<p>33. NAME OF PREVIOUS RESIDENCE None</p>	
<p>34. NAME OF PREVIOUS RESIDENCE None</p>		<p>35. NAME OF PREVIOUS RESIDENCE None</p>		<p>36. NAME OF PREVIOUS RESIDENCE None</p>	
<p>37. NAME OF PREVIOUS RESIDENCE None</p>		<p>38. NAME OF PREVIOUS RESIDENCE None</p>		<p>39. NAME OF PREVIOUS RESIDENCE None</p>	
<p>40. NAME OF PREVIOUS RESIDENCE None</p>		<p>41. NAME OF PREVIOUS RESIDENCE None</p>		<p>42. NAME OF PREVIOUS RESIDENCE None</p>	
<p>43. NAME OF PREVIOUS RESIDENCE None</p>		<p>44. NAME OF PREVIOUS RESIDENCE None</p>		<p>45. NAME OF PREVIOUS RESIDENCE None</p>	
<p>46. NAME OF PREVIOUS RESIDENCE None</p>		<p>47. NAME OF PREVIOUS RESIDENCE None</p>		<p>48. NAME OF PREVIOUS RESIDENCE None</p>	
<p>49. NAME OF PREVIOUS RESIDENCE None</p>		<p>50. NAME OF PREVIOUS RESIDENCE None</p>		<p>51. NAME OF PREVIOUS RESIDENCE None</p>	
<p>52. NAME OF PREVIOUS RESIDENCE None</p>		<p>53. NAME OF PREVIOUS RESIDENCE None</p>		<p>54. NAME OF PREVIOUS RESIDENCE None</p>	
<p>55. NAME OF PREVIOUS RESIDENCE None</p>		<p>56. NAME OF PREVIOUS RESIDENCE None</p>		<p>57. NAME OF PREVIOUS RESIDENCE None</p>	
<p>58. NAME OF PREVIOUS RESIDENCE None</p>		<p>59. NAME OF PREVIOUS RESIDENCE None</p>		<p>60. NAME OF PREVIOUS RESIDENCE None</p>	
<p>61. NAME OF PREVIOUS RESIDENCE None</p>		<p>62. NAME OF PREVIOUS RESIDENCE None</p>		<p>63. NAME OF PREVIOUS RESIDENCE None</p>	
<p>64. NAME OF PREVIOUS RESIDENCE None</p>		<p>65. NAME OF PREVIOUS RESIDENCE None</p>		<p>66. NAME OF PREVIOUS RESIDENCE None</p>	
<p>67. NAME OF PREVIOUS RESIDENCE None</p>		<p>68. NAME OF PREVIOUS RESIDENCE None</p>		<p>69. NAME OF PREVIOUS RESIDENCE None</p>	
<p>70. NAME OF PREVIOUS RESIDENCE None</p>		<p>71. NAME OF PREVIOUS RESIDENCE None</p>		<p>72. NAME OF PREVIOUS RESIDENCE None</p>	
<p>73. NAME OF PREVIOUS RESIDENCE None</p>		<p>74. NAME OF PREVIOUS RESIDENCE None</p>		<p>75. NAME OF PREVIOUS RESIDENCE None</p>	
<p>76. NAME OF PREVIOUS RESIDENCE None</p>		<p>77. NAME OF PREVIOUS RESIDENCE None</p>		<p>78. NAME OF PREVIOUS RESIDENCE None</p>	
<p>79. NAME OF PREVIOUS RESIDENCE None</p>		<p>80. NAME OF PREVIOUS RESIDENCE None</p>		<p>81. NAME OF PREVIOUS RESIDENCE None</p>	
<p>82. NAME OF PREVIOUS RESIDENCE None</p>		<p>83. NAME OF PREVIOUS RESIDENCE None</p>		<p>84. NAME OF PREVIOUS RESIDENCE None</p>	
<p>85. NAME OF PREVIOUS RESIDENCE None</p>		<p>86. NAME OF PREVIOUS RESIDENCE None</p>		<p>87. NAME OF PREVIOUS RESIDENCE None</p>	
<p>88. NAME OF PREVIOUS RESIDENCE None</p>		<p>89. NAME OF PREVIOUS RESIDENCE None</p>		<p>90. NAME OF PREVIOUS RESIDENCE None</p>	
<p>91. NAME OF PREVIOUS RESIDENCE None</p>		<p>92. NAME OF PREVIOUS RESIDENCE None</p>		<p>93. NAME OF PREVIOUS RESIDENCE None</p>	
<p>94. NAME OF PREVIOUS RESIDENCE None</p>		<p>95. NAME OF PREVIOUS RESIDENCE None</p>		<p>96. NAME OF PREVIOUS RESIDENCE None</p>	
<p>97. NAME OF PREVIOUS RESIDENCE None</p>		<p>98. NAME OF PREVIOUS RESIDENCE None</p>		<p>99. NAME OF PREVIOUS RESIDENCE None</p>	
<p>100. NAME OF PREVIOUS RESIDENCE None</p>		<p>101. NAME OF PREVIOUS RESIDENCE None</p>		<p>102. NAME OF PREVIOUS RESIDENCE None</p>	

NOT RECORDED

RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13697 CERTIFICATE OF DEATH

13679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN 1b 26 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock, Md. R.F.D.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harold J. Milligan				4. DATE OF DEATH Month Day Year Dec. 13, 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1902		9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Vienna, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Frank Milligan				14. MOTHER'S MAIDEN NAME Sallie Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. yes		17. INFORMANT Address Mrs. Harold Milligan Hurlock, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) ? years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 126 Bloomingdale Avenue 12-16-58							
ACTUAL SIGNATURE H. R. Trapnell M.D.				PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D. Federalsburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/17/58		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hurlock, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold J. Milligan ADDRESS Federalsburg, Md.				24a. REC'D BY REGISTRAR DATE DEC 19 '58		24b. REGISTRAR'S SIGNATURE Carlton E. Kneel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 12

13671

CERTIFICATE OF DEATH

Reg. Dist. No. 13680

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>8 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 Academy St.</u>				d. STREET ADDRESS <u>102 Academy St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Morris</u> Last <u></u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1873</u>		9. AGE (In years lost birthday) <u>85</u> yrs.	10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Morris</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hurst</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>102 Academy St.</u> <u>Mrs. Marilda W. Morris, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/2</u> , 19 <u>58</u> , to <u>12/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/9</u> , 19 <u>58</u> , and that death occurred at <u>9:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Loar St</u> DATE SIGNED <u>12/11/58</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Hanks</u>				<u>CAMBRIDGE Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. F. F.</u> ADDRESS <u>Easton, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. F. F.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Age at death: [illegible]
6. Sex: [illegible]
7. Race: [illegible]
8. Marital status: [illegible]
9. Occupation: [illegible]
10. Education: [illegible]
11. Religion: [illegible]
12. Burial place: [illegible]
13. Signature of physician: [illegible]
14. Signature of registrar: [illegible]
15. Date of registration: [illegible]

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10000

1. Name of deceased: [illegible]		2. Date of death: [illegible]	
3. Place of death: [illegible]		4. Cause of death: [illegible]	
5. Age at death: [illegible]		6. Sex: [illegible]	
7. Race: [illegible]		8. Marital status: [illegible]	
9. Occupation: [illegible]		10. Education: [illegible]	
11. Religion: [illegible]		12. Burial place: [illegible]	
13. Signature of physician: [illegible]		14. Signature of registrar: [illegible]	
15. Date of registration: [illegible]		16. [illegible]	
17. [illegible]		18. [illegible]	
19. [illegible]		20. [illegible]	
21. [illegible]		22. [illegible]	
23. [illegible]		24. [illegible]	
25. [illegible]		26. [illegible]	
27. [illegible]		28. [illegible]	
29. [illegible]		30. [illegible]	
31. [illegible]		32. [illegible]	
33. [illegible]		34. [illegible]	
35. [illegible]		36. [illegible]	
37. [illegible]		38. [illegible]	
39. [illegible]		40. [illegible]	
41. [illegible]		42. [illegible]	
43. [illegible]		44. [illegible]	
45. [illegible]		46. [illegible]	
47. [illegible]		48. [illegible]	
49. [illegible]		50. [illegible]	
51. [illegible]		52. [illegible]	
53. [illegible]		54. [illegible]	
55. [illegible]		56. [illegible]	
57. [illegible]		58. [illegible]	
59. [illegible]		60. [illegible]	
61. [illegible]		62. [illegible]	
63. [illegible]		64. [illegible]	
65. [illegible]		66. [illegible]	
67. [illegible]		68. [illegible]	
69. [illegible]		70. [illegible]	
71. [illegible]		72. [illegible]	
73. [illegible]		74. [illegible]	
75. [illegible]		76. [illegible]	
77. [illegible]		78. [illegible]	
79. [illegible]		80. [illegible]	
81. [illegible]		82. [illegible]	
83. [illegible]		84. [illegible]	
85. [illegible]		86. [illegible]	
87. [illegible]		88. [illegible]	
89. [illegible]		90. [illegible]	
91. [illegible]		92. [illegible]	
93. [illegible]		94. [illegible]	
95. [illegible]		96. [illegible]	
97. [illegible]		98. [illegible]	
99. [illegible]		100. [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13681

13698 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD #1-Cambridge, Md.</u>				c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cambridge</u> <u>RFD #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Payne</u>				4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1906</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dorchester-Co-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Payne</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Mae Ellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Nicie Payne-RFD #1-Camb., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 1, 1958</u> , to <u>December 2, 1958</u> , that I last saw the deceased alive on <u>December 2, 1958</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md. 12-2-58</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett, M.D.</u>				M.D. <u>227 Pine St-Cambridge, Md. 12-2-58</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rock, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. Sellers</u>				ADDRESS <u>High St-Camb., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Dec 1 9 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Celine P. Kane</u>			

13081

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH June 6, 1968		15. TIME OF DEATH 11:00 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover		23. SIGNATURE OF CHIEF OF POLICE J. Edgar Hoover		24. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		25. SIGNATURE OF JUDGE J. Edgar Hoover	
26. SIGNATURE OF SHERIFF J. Edgar Hoover		27. SIGNATURE OF TOWNSHIP CLERK J. Edgar Hoover		28. SIGNATURE OF COUNTY CLERK J. Edgar Hoover		29. SIGNATURE OF STATE CLERK J. Edgar Hoover		30. SIGNATURE OF FEDERAL CLERK J. Edgar Hoover	
31. SIGNATURE OF POSTAL CLERK J. Edgar Hoover		32. SIGNATURE OF AIR MAIL CLERK J. Edgar Hoover		33. SIGNATURE OF TELEGRAPH CLERK J. Edgar Hoover		34. SIGNATURE OF TELEPHONE CLERK J. Edgar Hoover		35. SIGNATURE OF RAILROAD CLERK J. Edgar Hoover	
36. SIGNATURE OF STEAMSHIP CLERK J. Edgar Hoover		37. SIGNATURE OF AIRCRAFT CLERK J. Edgar Hoover		38. SIGNATURE OF MOTOR VEHICLE CLERK J. Edgar Hoover		39. SIGNATURE OF BOAT CLERK J. Edgar Hoover		40. SIGNATURE OF OTHER CLERK J. Edgar Hoover	
41. SIGNATURE OF DECEASED J. Edgar Hoover		42. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		43. SIGNATURE OF PHYSICIAN J. Edgar Hoover		44. SIGNATURE OF CORONER J. Edgar Hoover		45. SIGNATURE OF WITNESS J. Edgar Hoover	
46. SIGNATURE OF DECEASED J. Edgar Hoover		47. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		48. SIGNATURE OF PHYSICIAN J. Edgar Hoover		49. SIGNATURE OF CORONER J. Edgar Hoover		50. SIGNATURE OF WITNESS J. Edgar Hoover	
49. SIGNATURE OF DECEASED J. Edgar Hoover		50. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		51. SIGNATURE OF PHYSICIAN J. Edgar Hoover		52. SIGNATURE OF CORONER J. Edgar Hoover		53. SIGNATURE OF WITNESS J. Edgar Hoover	
54. SIGNATURE OF DECEASED J. Edgar Hoover		55. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		56. SIGNATURE OF PHYSICIAN J. Edgar Hoover		57. SIGNATURE OF CORONER J. Edgar Hoover		58. SIGNATURE OF WITNESS J. Edgar Hoover	
59. SIGNATURE OF DECEASED J. Edgar Hoover		60. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		61. SIGNATURE OF PHYSICIAN J. Edgar Hoover		62. SIGNATURE OF CORONER J. Edgar Hoover		63. SIGNATURE OF WITNESS J. Edgar Hoover	
64. SIGNATURE OF DECEASED J. Edgar Hoover		65. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		66. SIGNATURE OF PHYSICIAN J. Edgar Hoover		67. SIGNATURE OF CORONER J. Edgar Hoover		68. SIGNATURE OF WITNESS J. Edgar Hoover	
69. SIGNATURE OF DECEASED J. Edgar Hoover		70. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		71. SIGNATURE OF PHYSICIAN J. Edgar Hoover		72. SIGNATURE OF CORONER J. Edgar Hoover		73. SIGNATURE OF WITNESS J. Edgar Hoover	
74. SIGNATURE OF DECEASED J. Edgar Hoover		75. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		76. SIGNATURE OF PHYSICIAN J. Edgar Hoover		77. SIGNATURE OF CORONER J. Edgar Hoover		78. SIGNATURE OF WITNESS J. Edgar Hoover	
79. SIGNATURE OF DECEASED J. Edgar Hoover		80. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		81. SIGNATURE OF PHYSICIAN J. Edgar Hoover		82. SIGNATURE OF CORONER J. Edgar Hoover		83. SIGNATURE OF WITNESS J. Edgar Hoover	
84. SIGNATURE OF DECEASED J. Edgar Hoover		85. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		86. SIGNATURE OF PHYSICIAN J. Edgar Hoover		87. SIGNATURE OF CORONER J. Edgar Hoover		88. SIGNATURE OF WITNESS J. Edgar Hoover	
89. SIGNATURE OF DECEASED J. Edgar Hoover		90. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		91. SIGNATURE OF PHYSICIAN J. Edgar Hoover		92. SIGNATURE OF CORONER J. Edgar Hoover		93. SIGNATURE OF WITNESS J. Edgar Hoover	
94. SIGNATURE OF DECEASED J. Edgar Hoover		95. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		96. SIGNATURE OF PHYSICIAN J. Edgar Hoover		97. SIGNATURE OF CORONER J. Edgar Hoover		98. SIGNATURE OF WITNESS J. Edgar Hoover	
99. SIGNATURE OF DECEASED J. Edgar Hoover		100. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		101. SIGNATURE OF PHYSICIAN J. Edgar Hoover		102. SIGNATURE OF CORONER J. Edgar Hoover		103. SIGNATURE OF WITNESS J. Edgar Hoover	

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13699 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Cook Cty		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek		c. LENGTH OF STAY IN 1b 10 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fishing Creek, Md.			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) John Thomas Perine			4. DATE OF DEATH Month December Day 18 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1856		9. AGE (In years last birthday) 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipper (Office Work)		10b. KIND OF BUSINESS OR INDUSTRY Roofing		11. BIRTHPLACE (State or foreign country) Illinois	
13. FATHER'S NAME John David Perine			14. MOTHER'S MAIDEN NAME Nannie Maddix		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Eugenia Gerstley	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fall (c) Old age					INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walking across floor and fell (Possible dislocation left hip)			
20c. TIME OF INJURY Month, Day, Year Hour 10 a. m. Dec. 11 19 58 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Fishing Creek, Dorchester, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/18/58	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/58		22c. NAME OF CEMETERY OR CREMATORY South Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service		ADDRESS Cambridge, Md.		22d. LOCATION (City, town, or county) (State) Vandalia Ill.	
		24a. REC'D BY REGISTRAR DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

MEDICAL CERTIFICATION

00

09

2

Replacement: Film 238 2-2-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13683

Reg. Dist. No.

13672

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 4 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 809 Race Street		d. STREET ADDRESS 809 Race Street	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Rogers Last Rogers		4. DATE OF DEATH Month Dec. Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Office Worker		10b. KIND OF BUSINESS OR INDUSTRY Pittsburgh, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Christopher Rogers		14. MOTHER'S MAIDEN NAME Elizabeth Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Albert Lybrand, 809 Race St., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/4/58	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Dec. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
22d. LOCATION (City, town, or county) (State) Washington, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE Lemuel K. Thomas	
24a. REC'D BY REGISTRAR DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13700

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Cambridge Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Cambridge R F D # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lucy First Elzey Middle Rossy Last			4. DATE OF DEATH Month Dec Day 19 Year 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1901		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done, including life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Elzey			14. MOTHER'S MAIDEN NAME Mary Sharter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Calvin Rossey Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Maco Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Maco Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Dorchester Men Park	
				22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LeCompte Funeral Service Cambridge Maryland.			24a. REC'D BY REGISTRAR DATE DEC 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13701

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market - Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Linkwood				d. STREET ADDRESS Near Linkwood			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Clarence Middle Herman Last Sampson				4. DATE OF DEATH Month December Day 7 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm Laborer		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Sampson				14. MOTHER'S MAIDEN NAME Annie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-2145		17. INFORMANT Mrs. Mildred Banks, East New Market, Md., RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Decompensation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 6, 1958 , to December 7, 1958 , that I last saw the deceased alive on December 7, 1958 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>				ADDRESS (Street, city or town, state) 227 Pine St - Cambridge, Md.			
DATE SIGNED 12-13-58							
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10, 1958		22c. NAME OF CEMETERY OR CREMATORY East New Market Co. Cemetery, East New Market, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13702

CERTIFICATE OF DEATH

13686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Cambridge		c. LENGTH OF STAY IN 1b 1 yr. 11 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		2040-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 108 Goldsborough St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Mae Last Stevenson		4. DATE OF DEATH Month Dec. Day 23 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-75
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE John Carver		14. MOTHER'S MAIDEN NAME HARRIET P. POTTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 170-20-5376	
17. INFORMANT E.S.S. Hospital records		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2- , 19 57 , to 12-23- , 19 58 , that I last saw the deceased alive on 12-22- , 19 58 and that death occurred at 8:35 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Currier		ADDRESS (Street, city or town, state) DATE SIGNED Rt. 2, Cambridge, Maryland 12-23-58	
PHYSICIAN'S NAME (Type) George E. Currier, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12/27/58	22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	22d. LOCATION (City, town, or county) (State) Oxford Md
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman & Son Easton Md.		24a. REC'D BY REGISTRAR JAN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13673

CERTIFICATE OF DEATH

13687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Dorchester M. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 809 Talisman Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lena P. Teider		4. DATE OF DEATH Month Dec. Day 19 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1881
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Frank Ero		Address Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemaplegia, right, recent and old DUE TO (c) Arteriosclerosis, generalized and cerebral			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 X Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-28-53 , 19____, to 12-19-58 , 19____, that I last saw the deceased alive on 12-19-58 , 19____, and that death occurred at 11:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 12-20-58			
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. 15 Locust Street, Cambridge, Md.	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21, 1958	22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Park	22d. LOCATION (City, town, or county) (State) Cambridge Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Maryland.	
24a. REC'D BY REGISTRAR DATE DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13703 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S. State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence James Thompson		4. DATE OF DEATH Month Dec. Day 29 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY Shoemaker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Thompson		14. MOTHER'S MAIDEN NAME Emma Jewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 18 7002	
17. INFORMANT Records E.S.S. hospital.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 12/29/58	
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-2-59	
22c. NAME OF CEMETERY OR CREMATORY STILL CEMETERY		22d. LOCATION (City, town, or county) (State) STILL POND, MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Victor H. ...</i>		ADDRESS STILL POND, MD.	
24a. REC'D BY REGISTRAR JAN 5 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.
1930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

EVANSTON
BOND

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE: [illegible]

1/25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13704

CERTIFICATE OF DEATH

13689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		c. LENGTH OF STAY IN 1b <u>ad life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		d. STREET ADDRESS <u>Main</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Irving</u> Last <u>Tilghman</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hand grower - rat</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>business</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Tilghman</u>		14. MOTHER'S MAIDEN NAME <u>Emma Tilghman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Elizabeth Tilghman</u> Address <u>E. N. Market</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HT. DISEASE</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PARKINSON'S DISEASE</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNDET</u> <u>UNDET</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1958</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/6</u> , 19 <u>58</u> , to <u>12/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>58</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 RACE ST</u> DATE SIGNED <u>12/9/58</u>			
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.		DATE SIGNED <u>12/9/58</u>	
PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>		<u>CAMBRIDGE, MD.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	22d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Tilghman</u>		24a. REC'D BY REGISTRAR <u>DEC 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Anthony S. Tilghman</u>		24c. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13690

Reg. Dist. No.

13674

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write nearest town) Cambridge		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crocheron	
d. NAME OF HOSPITAL (If not in hospital, give street address) Cambridge Maryland Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard S. Todd		4. DATE OF DEATH Month Dec Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 14, 1886
9. AGE (In years lost birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William E. Todd		14. MOTHER'S MAIDEN NAME Catherine Roberson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs Oattie Todd		Address Toddville Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 446 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days 1 wk.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/2 , 19 58 , to 12/3 , 19 58 , that I last saw the deceased alive on 12/3/58 , and that death occurred at 10:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence Maryanov		ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md.	
PHYSICIAN'S NAME (Type) Lawrence Maryanov		DATE SIGNED 12/5/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 7, 1958	22c. NAME OF CEMETERY OR CREMATORY Dorchester Men. Park	22d. LOCATION (City, town, or county) (State) Cambridge Maryland
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR DEC 8 '58	
ADDRESS Cambridge Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13691

13675

Item 9 Film 6236 12-11-58 et

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS Race Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter J. Vickers First Middle Last 4. DATE OF DEATH Dec. 6, 1958 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 23, 1897 9. AGE (In years last birthday) 61 60 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Repair 10b. KIND OF BUSINESS OR INDUSTRY Own Garage 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Thomas J Vickers 14. MOTHER'S MAIDEN NAME Sarah Keyes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Mrs Calvin Stack Address Cambridge Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. John Mace Jr. EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Dec, 9, 1958 22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park 22d. LOCATION (City, town, or county) (State) Cambridge Maryland		23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service ADDRESS Cambridge Maryland. 24a. REC'D BY REGISTRAR DEC 9 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13676

Reg. Dist. No.

14430

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMbridge</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMbridge</u> <u>13</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>234 Cedar St</u>				d. STREET ADDRESS <u>234 Cedar St</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Harry</u> Last <u>WALLS</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>Unknown</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>231-056717</u>		17. INFORMANT <u>Malcolm Anderson</u>		Address <u>CAMbridge</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Silent City</u>		22d. LOCATION (City, town, or county) (State) <u>CAMbridge</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>				ADDRESS <u>CAMbridge</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

11400

11400

<p>1. Name of deceased: _____</p>	
<p>2. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Manner of death: _____</p>	
<p>8. Signature of Medical Examiner: _____</p>	
<p>9. Signature of Coroner: _____</p>	
<p>10. Signature of Registrar: _____</p>	
<p>11. Signature of Physician: _____</p>	
<p>12. Signature of Family: _____</p>	
<p>13. Signature of Other: _____</p>	
<p>14. Signature of Other: _____</p>	
<p>15. Signature of Other: _____</p>	
<p>16. Signature of Other: _____</p>	
<p>17. Signature of Other: _____</p>	
<p>18. Signature of Other: _____</p>	
<p>19. Signature of Other: _____</p>	
<p>20. Signature of Other: _____</p>	
<p>21. Signature of Other: _____</p>	
<p>22. Signature of Other: _____</p>	
<p>23. Signature of Other: _____</p>	
<p>24. Signature of Other: _____</p>	
<p>25. Signature of Other: _____</p>	
<p>26. Signature of Other: _____</p>	
<p>27. Signature of Other: _____</p>	
<p>28. Signature of Other: _____</p>	
<p>29. Signature of Other: _____</p>	
<p>30. Signature of Other: _____</p>	
<p>31. Signature of Other: _____</p>	
<p>32. Signature of Other: _____</p>	
<p>33. Signature of Other: _____</p>	
<p>34. Signature of Other: _____</p>	
<p>35. Signature of Other: _____</p>	
<p>36. Signature of Other: _____</p>	
<p>37. Signature of Other: _____</p>	
<p>38. Signature of Other: _____</p>	
<p>39. Signature of Other: _____</p>	
<p>40. Signature of Other: _____</p>	
<p>41. Signature of Other: _____</p>	
<p>42. Signature of Other: _____</p>	
<p>43. Signature of Other: _____</p>	
<p>44. Signature of Other: _____</p>	
<p>45. Signature of Other: _____</p>	
<p>46. Signature of Other: _____</p>	
<p>47. Signature of Other: _____</p>	
<p>48. Signature of Other: _____</p>	
<p>49. Signature of Other: _____</p>	
<p>50. Signature of Other: _____</p>	
<p>51. Signature of Other: _____</p>	
<p>52. Signature of Other: _____</p>	
<p>53. Signature of Other: _____</p>	
<p>54. Signature of Other: _____</p>	
<p>55. Signature of Other: _____</p>	
<p>56. Signature of Other: _____</p>	
<p>57. Signature of Other: _____</p>	
<p>58. Signature of Other: _____</p>	
<p>59. Signature of Other: _____</p>	
<p>60. Signature of Other: _____</p>	
<p>61. Signature of Other: _____</p>	
<p>62. Signature of Other: _____</p>	
<p>63. Signature of Other: _____</p>	
<p>64. Signature of Other: _____</p>	
<p>65. Signature of Other: _____</p>	
<p>66. Signature of Other: _____</p>	
<p>67. Signature of Other: _____</p>	
<p>68. Signature of Other: _____</p>	
<p>69. Signature of Other: _____</p>	
<p>70. Signature of Other: _____</p>	
<p>71. Signature of Other: _____</p>	
<p>72. Signature of Other: _____</p>	
<p>73. Signature of Other: _____</p>	
<p>74. Signature of Other: _____</p>	
<p>75. Signature of Other: _____</p>	
<p>76. Signature of Other: _____</p>	
<p>77. Signature of Other: _____</p>	
<p>78. Signature of Other: _____</p>	
<p>79. Signature of Other: _____</p>	
<p>80. Signature of Other: _____</p>	
<p>81. Signature of Other: _____</p>	
<p>82. Signature of Other: _____</p>	
<p>83. Signature of Other: _____</p>	
<p>84. Signature of Other: _____</p>	
<p>85. Signature of Other: _____</p>	
<p>86. Signature of Other: _____</p>	
<p>87. Signature of Other: _____</p>	
<p>88. Signature of Other: _____</p>	
<p>89. Signature of Other: _____</p>	
<p>90. Signature of Other: _____</p>	
<p>91. Signature of Other: _____</p>	
<p>92. Signature of Other: _____</p>	
<p>93. Signature of Other: _____</p>	
<p>94. Signature of Other: _____</p>	
<p>95. Signature of Other: _____</p>	
<p>96. Signature of Other: _____</p>	
<p>97. Signature of Other: _____</p>	
<p>98. Signature of Other: _____</p>	
<p>99. Signature of Other: _____</p>	
<p>100. Signature of Other: _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14431

Reg. Dist. No.

13677

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Corner High and Pine Sts.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge d. STREET ADDRESS Corner High and Pine St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Patricia Ann Wongus		4. DATE OF DEATH Dec. 18 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1958
9. AGE (In years last birthday) 2 yrs. 8 Months		10. IF UNDER 1 YEAR 2 8 IF UNDER 24 HRS. 2 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Luke Brannock		14. MOTHER'S MAIDEN NAME Rosalie Wongus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rosalie Wongus		Address High and Pine St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute respiratory infection 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED 1/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/58	22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Dor. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert StClair		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR JAN 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kious	

2067172xv4

